

# Challenges and Issues in Internationally Adopted Children Including Factors that Impact Speech and Language Development

An Honors Thesis (HONRS 499)

by

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Abstract

This paper discusses a variety of issues and challenges that health care professionals, especially speech pathologists, should be aware of when working with internationally adopted children in the United States. The information is divided into three sections. Section I provides the history of international adoptions in the United States, as well as the medical, developmental, and the sensory integration concerns associated with this population. Section II focuses on the following issues related to language development in internationally adopted children: theories on language development, early speech and language development, language delays and disorders, second language acquisition, the assessment of speech and language disorders, and appropriate intervention services. Section III discusses my interviews with four mothers of internationally adopted children in the Muncie, IN area.

*"The soul is healed by being with children".  
Fyodor Dostoyevski*

## REVIEW OF LITERATURE

### SECTION I: HISTORY, MEDICAL, AND DEVELOPMENTAL CONCERNS

#### HISTORY/STATISTICS OF INTERNATIONAL ADOPTIONS

International adoptions are becoming increasingly more common worldwide, with the United States leading in the number of children adopted from outside of the country each year. Prior to the 1940's, international adoptions were not widely approved of in the United States; however, beginning with World War II, Americans became more cognizant of the wars, poverty, and social upheavals abroad. These factors greatly increased the number of orphaned or abandoned children, and as a result international adoptions became part of the overall humanitarian effort "as a solution to the problem of parentless children" (Rojewski & Rojewski, 2001, p3). After World War II, the Korean War, and the Vietnam War, the number of international adoptions by Americans successively rose. In addition to major wars, extreme poverty and political unrest in Latin America, the former Soviet Union, and Eastern Europe also resulted in increased numbers of children without families. (Federici, 1998).

Over the past ten years the number of children adopted from China has dramatically increased as well. Currently, China is the primary source of internationally adopted children, with 25% of total adoptions (Eva B Donaldson Adoption Institute, 1997). In 1991, China enacted adoption laws that lessened some of the former restrictions on international adoptions. With these laws, the government hoped to alleviate some of the burden placed on state-run orphanages providing care for the large numbers of abandoned children (Rojewski & Rojewski, 2001). The number of children abandoned in China is conservatively estimated to

be between 100,000 and 600,000 annually (Rojewski & Rojewski, 2001). Among the reasons for these high numbers are “the role of the family in Chinese society, the importance of sons, ideology and tradition regarding motherhood and women’s roles in Chinese society, gender inequalities, and government fertility restrictions” (Rojewski & Rojewski, 2001 p5).

In 2001, the number of internationally adopted children in the United States was 19,237; whereas, in 1991 the number was 9,050. (Eva B. Donaldson Adoption Institute, 1997). This recent increase has been attributed to several factors including the shortage of adoptable children in the United States with the commonly desired age and racial characteristics (Johnson & Dole, 1999). Rojewski & Rojewski also report that waiting periods of up to seven years or more are not uncommon when adopting children in the United States (2001). In addition, concerns about birth parents failing to give up their parental rights or returning to claim children already adopted dissuade people from pursuing domestic adoptions; thus, more and more people turn to international adoption agencies in hopes of finding children to complete their families.

#### IMPLICATIONS FOR HEALTH CARE PROFESSIONALS IN THE UNITED STATES

The increase in the number of international adoptions has created a distinct population of children with their own special challenges and needs, who require services from a variety of health care professionals. Upon their arrival to the United States these children should receive complete medical and developmental evaluations, and referral for any necessary intervention services should immediately follow. The role of the speech pathologist in the early intervention process for these children is especially significant due to the high percentage with speech and language problems. In order to provide proper speech and language services to this population, the speech pathologist should be aware of the various

medical and developmental risk factors in adopted children. They should especially be knowledgeable about language concerns, including aspects related to their English development, and the means of assessing and providing intervention services throughout their growth and development.

### MEDICAL AND DEVELOPMENTAL CONCERNS

In recent years, the number of health and developmental problems in the internationally adopted population has increased significantly. This increase is in a large part due to the adopted children's countries' of origin. In the 1980's, two-thirds of adopted children were from Korea, where the standard of living and quality of care for the children was relatively high. However, the increase in demand for adoptable children combined with a decrease in the number of available children in Korea shifted the main sources of adoptable children to China and countries in Eastern Europe where care was poorer. In 1998, 88% of internationally adopted children came from countries with lower standards of living and inadequate levels of health care (Johnson & Dole, 1999). Internationally adopted children may subsist in orphanages and institutionalized settings for months to years, and the risk factors for medical and developmental problems that accompany these environments are extremely high.

Currently, all children are required to be examined in their native country by a medical physician designated by the US Department of State before they are issued immigrant visas. This examination screens only for certain communicable disease and/or serious mental defects and is not a comprehensive medical evaluation (American Academy of Pediatrics, 2000). Parents can meet with a physician prior to adopting in order to go over possible medical

concerns, and they should consult a physician after the child arrives to the United States for a complete medical evaluation.

Infectious diseases are among the most commonly diagnosed medical conditions in internationally adopted children. The rate of tuberculosis in internationally adopted children is 8 to 13 times higher than those in American children (American Academy of Pediatrics, 2000). In addition to infectious diseases, hearing loss and visual abnormalities, growth and developmental retardation, nutritional deficiencies, and congenital anomalies are common diagnoses (American Academy of Pediatrics, 2000). Studies have found that more than 50% of adopted children from Eastern Europe had some kind of undiagnosed medical condition when initially evaluated in the United States (Judge, 1999).

The medical risk factors in internationally adopted children are widely varied in type and severity. These factors depend a great deal on the adopted child's native country and the orphanage's living conditions, which are often breeding grounds for illnesses and diseases rarely seen in the United States (Federici, 1998). International adoptees commonly lack the proper immunizations recommended by the World Health Organization (Judge, 1999). In Asia, hygiene and medical care in orphanages are poor, and diseases such as malaria, hepatitis and tuberculosis are prevalent. In Latin America, the foster care systems appear to be better than in Asia and Eastern Europe, but other risk factors such as fetal exposure to alcohol, cigarette smoke, and other neurotoxins exist (Federici, 1998). The children residing in orphanages and institutions in Eastern Europe seem to receive the lowest standard of care. Colds, flues, pneumonia, and chronic ear infections are rarely treated and can lead to serious medical problems (Federici, 1998). Infectious diseases such as tuberculosis, active hepatitis B and C, HIV, intestinal parasites, and congenital syphilis are common (Judge, 1999), along

with various other medical problems such as congenital heart disease, Fetal Alcohol Syndrome (FAS), anemia, and hearing loss.

In addition to specific medical conditions, malnutrition is a common condition in children living in foreign institutions. Malnourished infants may be listless, apathetic, motionless, and irritable. Some infants may be unresponsive or resist social interaction and many prefer inanimate objects (Beeler, 1990). Malnutrition, “when accompanied with other socioeconomic deprivations that generally accompany it, is associated with retarded brain growth and mental development that persists into adult life” (Judge, 1999, p 246). Research has shown, however, that children seem to recover from malnutrition if they receive proper stimulation and amounts of food (Judge, 1999).

Malnourishment and exposure to toxins during prenatal development are also risk factors for developmental and behavioral problems later in life. Dana Johnson, the Director of the International Adoption Clinic at the University of Minnesota, reported that out of 252 children from Eastern Europe who were evaluated by the clinic, 76% of the children were abandoned or relinquished by their parents due to social or economic reasons (Johnson & Dole, 1999). Mothers attempting to survive in politically unstable and poverty stricken environments are not likely to receive proper prenatal care. In Asia, mothers commonly work up until childbirth and then have the child at home (Federici, 1998). Fetal Alcohol Syndrome (FAS) is also a concern, especially in children adopted from Russia, where alcohol consumption by women has increased in recent years. “Alcohol consumption during pregnancy is associated with growth retardation, central nervous system anomalies, and facial dysmorphology” (Judge, 1999, p245). Alcohol, nicotine, lead, and cocaine have each been linked to a variety of behavioral problems, and in some children lead has been directly linked

to violent behaviors such as aggression, rage, and paranoia (Karr-Morse & Wiley, 1997). Unfortunately, the individual prenatal and early developmental histories of the majority of internationally adopted children are unknown. In general, though, research has linked prenatal exposure to drugs and malnutrition to a host of problems that can affect people throughout their entire lives.

Along with malnutrition, neglect and abuse can also contribute to a number of developmental delays, and internationally adopted children are at a higher risk for one or more of these factors. Most institutions have a very low caretaker to child ratio, and some countries in Eastern Europe have only one caretaker per 50 infants. In the countries of the former Soviet Union, decades of oppression and neglect along with the poor quality of health care have been linked to delays in physical growth and development (Federici, 1998). Studies of children adopted from Eastern Europe have shown that a child living in an orphanage is estimated to lose one month of linear growth for every 3 to 5 months in the orphanage. Length, height, weight, head circumference, and weight for height ratios decreased as time in the institution increased (Judge, 1999). Studies dealing with maltreated children in the United States have indicated that such infants demonstrate cognitive delays even during their first year of life. Maltreated children may not develop proper social skills and can be aggressive, withdrawn, and passive. A study by Allen & Oliver (1982) on preschool children who had been abused and/or neglected, indicated that child neglect “significantly predicted poorer language abilities, while child abuse did not correlate” (as cited by Hough, 1996, p 100). Many researchers who have followed internationally adopted children have reported problems such as Failure to Thrive Syndrome, sleep and feeding disorders, and early onset emotional-behavioral problems (Federici, 1998).



### SENSORY INTEGRATION CONCERNS

Another area of concern in internationally adopted children is in their sensory integration and sensory processing abilities. “Sensory integration refers to the ability to organize, integrate, and use sensory information from the body and the environment” (Mauer, 1999, 383). The basic concept of sensory integration developed from the work of Jeanne Ayers (1979) who studied the neurosciences, physical development, and neuromuscular function. One of Ayers’ underlying principles of the SI theory was that the relationships between the senses (auditory, visual, olfactory, vestibular, tactile, gustatory, and proprioceptive), in development and function are interdependent (as cited in Mauer, 1999). The system is continuously expanding and building off of each new level. Ayers stated that the development of the tactile, vestibular, and proprioceptive systems gives children the foundation to learn about the objects and the actions of objects in their environment. Through the development of the visual and auditory systems, the children are then able “to develop meaningful associations between visual and auditory information and what is experienced in movement and touch” (as cited in Mauer, 1999, p385). The ability to accurately process sensory information helps create the foundation for further emotional development, social relationships, physical interactions, and cognitive performance (Cermak & Groza, 1998).

Under normal circumstances SI develops in children without problems; however, children who spend the beginning months or years in an institution will not be exposed to opportunities for proper sensory stimulation. These children are deprived of mothers or parental figures to interact with and provide the touch and movements that contribute to emotional and physical growth and development (Cermak & Groza, 1998). Infants and toddlers in institutions are often left confined to cribs, without opportunities for exploring and

interacting with their surroundings. Rooms and walls are bare, and toys and other stimulating objects are not provided. Methods of reducing mobility by keeping children confined or tied up, along with abuse by the institution staff are not uncommon and have been especially noted in institutions in Romania and Russia (Federici, 1998). A study by Cermak and Daunhauer (1997) found that adopted children from Romanian orphanages, when compared to their non-adopted peers, showed more problems in 5 out of 6 sensory processing areas (as cited by Judge, 1999). The results of this and several other studies on children from Romanian orphanages “support the conclusion that maternal-paternal deprivation, reduced handling, reduced opportunities for interaction, and overall decreased stimulation caused by early institutionalization could contribute to sensory integration problems (Judge, 1999, p246).”

Children with sensory integration problems may demonstrate delays in a wide range of areas, with each child showing slightly different symptoms (Cermak & Groza, 1998). Children who have difficulties with sensory discrimination, which is important in developing body awareness, may have problems with motor planning (dyspraxia). This can affect both their gross and fine motor skills. Problems with sensory modulation, which relates to how incoming information is regulated, are seen in children who are over-sensitive or under-sensitive to sensory stimulation. Children who are hypersensitive are sometimes described as sensory defensive and may avoid or negatively respond to certain stimuli or situations involving certain stimuli Cermak & Groza, 1998). Sensory defensiveness may cause children to overreact to and avoid light touches, certain textures of clothing or foods, sounds, especially high pitched ones, light, and/or smells (Cermak & Groza, 1998). Because proper speech and language development depends on multiple sensory processes, sensory

dysfunction can contribute to delayed communication development and academic achievement in children (Mauer, 1999).

Sensory integration problems are also associated with attachment issues, which commonly develop among internationally adopted children. Numerous studies have supported that “there is a close and cyclical relationship between sensory processing and the formations of close (i.e., attachment) relationships that is essential for normal infant development” (Judge, 1999, p246). Attachment refers to “the capacity of an infant or child to form a close, trusting and loving relationship with his mother and father” (Buenning, 1999). “A lack of trust generates feelings of aloneness, being different, pervasive anger, and an inordinate need for control. A trusting bond is essential in continued personality and conscience development, and serves as the foundation for future intimate relationships” (Levy & Orlans, 1998). Reactive Attachment Disorder develops when children are unable to attach or bond with their parents (Buenning, 1999). The limited personal interactions internationally adopted children have with their caregivers and absence of strong maternal bonding places the children at risk for attachment problems. Even young infants who are adopted may demonstrate attachment problems because of the failure to bond in the original parent-child relationship (Buenning, 1999). Reactive Attachment disorder can range in severity from mild to severe, and the level is directly related to the type and duration of the trauma the child experienced. Parents of children older than 3 years who were adopted from Eastern Europe stated that it took longer for the child to adjust to living with their family; however, with time the majority of the children adjusted well to their adoptive homes (Judge, 1999, p248). Early detection and intervention of RAD is the most effective way of treating the problem, and educating parents about the symptoms can speed up the initial diagnosis. (Buenning, 1999).

## SECTION II: LANGUAGE CONCERNS

*“Language is a leading psychological function that mediates practically all other psychological competencies such as perception, memory, cognition, goal-oriented behavior and others” (Gindis, 2002).*

### THEORIES OF LANGUAGE DEVELOPMENT

Throughout the past fifty years, several different models have been proposed to explain how humans develop language. The Behaviorist Interpretation Model of the 1960's claimed that the environment was the most critical factor in language acquisition. Language was not considered to be an innate human behavior but was learned through constant stimulation, imitation, and reinforcement. This theory, however, did not account for the fact that a great deal of language production is spontaneous. Children are capable of creating their own utterances that they have never heard or said before. In the 1970's the Nativists proposed that humans are predisposed to learn language. Noam Chomsky developed the concept of the Language Acquisition Device (LAD), possessed by all humans and carrying the information necessary for learning language. The most recent view is the Social Interactionist interpretation, which proposes that both biology and the environment contribute to language acquisition. Language develops as a result of the social interactions early in life. As children develop language their communication and social skills increase, which prompts more complex language development. This cycle continues to build until language skills reach adult levels. (Huitt and Howard, 1997, p6-38).

### SPEECH/LANGUAGE DEVELOPMENT

The development of speech and language is a complex process that children are preparing for long before they say their first words. From the beginning they use all parts of their communication system, especially their receptive component (Hulit & Howard, 1997). The ability to perceive auditory information, an integral part of speech and language development, exists even before birth. By the twenty-fifth week of gestation, the fetus's auditory system is functional, and by the thirty-fifth week its level of hearing is near that of an adult's (Boysson-Bardies, 1999). The fetus is able to hear its mother's voice and the voices of others from inside of the womb. Several studies have focused on fetus's reactions to various auditory stimuli. A study by Leacanuet and Granier-Deferre (1993) found that fetuses between thirty-six and forty weeks old were able to distinguish between two separate disyllables, [babi] and [biba] (as cited by Boysson-Bardies, 1999).

At birth, infants can distinguish between a wide range of consonant and vowel contrasts, even if the sounds are not part of the language to which they are being exposed (Boysson-Bardies, 1999). However, infants soon begin to select the sounds and combinations of sounds used in their language. They also integrate the prosodic cues, including accent, rhyme, and intonation of the language (Boysson-Bardies, 1999). Beginning around the fourth or fifth month infants' vocalizations become progressively more voluntary, and they begin to regulate the pitch, intensity, duration, and the consonants in the sounds they produce. They seem to become aware that their cooing has an impact on those around them, and they begin to use it to express their emotions and demands (Boysson-Bardies, 1999). Increasingly more research points to the fact that infants are preparing themselves for speech by "sharpening

their vocal capabilities, organizing their perceptual capacities, and conversing with adults through looks, sounds, and gestures” (Boysson-Bardies, 1999, p35).

Children’s cognitive development, memory, and perceptual abilities all interact and contribute towards their language development (Hulit & Howard, 1997). Also important, are children’s social interactions with caregivers. Halliday (1975) and Bruner (1981) found that infants are interested in establishing contact with others. Children between 8 and 12 months of age begin using a variety of gestures or vocalizations that express their wants and needs, their desire to control and interact with other people, and their emotions. When caregivers respond and expand on behaviors such as eye contact, gesturing, crying, babbling, and other vocalizations, infants recognize these behaviors as intentional communication and produce them more often (Hulit & Howard, 1997). Vocal communication between people arouses and maintains the infant’s desire to speak (Boysson-Bardies, 1999). Overall, the infant-adult interactions encourage children to communicate and play a crucial role in their language development.

#### LANGUAGE DELAYS/DISORDERS IN INTERNATIONALLY ADOPTED CHILDREN

Children who are referred to a speech pathologist for language concerns may exhibit any number of deficits in their language abilities for a variety of reasons. It is important that parents and professionals are able to recognize possible speech and language problems so that the appropriate steps towards intervention are taken. Internationally adopted children with language difficulties may have an underlying language disorder or may be experiencing a temporary delay in their language, both of which will affect their acquisition of English as a second language.

Adopted children may demonstrate a language or speech disorder in their native language, which will carry over as they learn English as a second language. The American Speech-Language Hearing Association (ASHA) defines a language disorder as “the abnormal acquisition, comprehension, or expression of spoken or written language. The disorder may involve all, one, or some of the phonologic, morphologic, semantic, syntactic, or pragmatic components of the linguistic system. Individuals with language disorders frequently have problems in sentence processing or in abstracting information meaningfully for storage and retrieval from short and long term memory” (Bernstein & Tiegerman-Farber, 1997). Often times, speech and language disorders create long-term problems and directly impact academic functioning (Hough, 1996). Frustration and behavior problems can result from the child’s inability to communicate his/her emotions, which can make the child’s adjustment to his/her new family and environment even more difficult.

A language disorder in an internationally adopted child may be the result of any number of factors from the child’s previous life. In the United States, the greatest risk factor for a child to develop speech and language problems is a family history of speech and language problems. Learning disabilities, stuttering, and dyslexia, which are associated with language/learning problems, have been genetically linked (Hough, 1996). The family histories of internationally adopted children are not known, though, making it impossible to determine risk based on these factors. The lack of stimulation and the overall deprivation in institutions and orphanages can significantly hinder a child’s native language development. Research has shown that language stimulation at a young age begins to shape children’s later language skills (Hough, 1996). A number of other risk factors, such as fetal alcohol exposure,

hearing loss, low birth weight or untreated medical problems, can also contribute to delayed language development (Hough, 1996).

The number of controlled studies on post-institutionalized children is limited, and the majority of the completed studies were based on children from Eastern European and Russian orphanages, where the conditions seem to be the harshest. Based on his experiences in Russian orphanages, Federici reported that some children learn to speak an “institutional language” which is a “combination of gibberish and babbling” (Federici, 1998 p71). He also remarked that the children in general remained passively lying still or rocking back and forth (Hough, 1996). Groze and Illeana stated that “the children did not ‘jabber’ to each other and there was little interaction between them” (Hough, 1996, p101). Between 55% to 60% of children adopted from Eastern Europe have shown some type of speech and language deficit (Judge, 1999). A Russian study that examined the language development of children 2.6 years of age living in a Russian orphanage indicated that 60% of the children had no expressive language at all. One year later only 14% of the children were using two-word utterances (Hough, 1996). Based on a survey of parents of 475 children adopted from Romania and the United States between 1990 and 1993, Groze (1996) concluded that children from institutions were more likely to have delayed language skills, along with other developmental delays (as cited in Hough, 1996).

Few studies have been conducted on children adopted from China, although several are currently in progress. Based on the preliminary results of their studies on children adopted from China and Eastern Europe as infants and toddlers, researchers reported that “despite initial delays, the long-range outcome (two years or more post-adoption) is quite



good and the percentage of children with persistent speech-language disorders is fairly small” (Polluck, Roberts, & Glennon, 2002).

## SECOND LANGUAGE ACQUISITION

The adopted child is forced not only to adjust to his or her new family and environment, but also to the new language. Most adopted children have had very little exposure to English, and their newly adopted parents cannot speak their children’s native language. The inability to communicate with their families combined with the frustration or anger they may already be feeling can create an extremely challenging situation for all people involved (Judge, 1999). During the process of language acquisition children may show negative emotional and behavior patterns such as anger, acting out, and temper tantrums (Gindis, 1997). Eventually, though, all adopted children will learn to speak English, and virtually all will speak it without an accent depending on whether or not they learned English before or after puberty (Gindis, 1997). However, the rate and ease at which children acquire their English skills varies from child to child.

The amount of success these children have in learning English may depend on a number of factors, including their adopted family, their age, their personality, and the amount of time they spent in the institution. A child’s ability to learn English is not solely related to their cognitive abilities. “Language acquisition is a very complex process where intellectual abilities are only one of many factors and by no means the process of second language acquiring is a straight reflection of intelligence” (Gindis, 1997, p91). Children between the ages of 4 and 8 years are the most at risk group for difficulties in acquiring English. The language problems of children between 4 and 8 years are “difficult to pinpoint because they are disguised by the dynamic of second language acquisition, which is mostly in

communication, not in the cognitive area” (Gindis, 1997, p93). Children younger than 4 are still in the process of language development, and children older than 8 may be able to transfer some of their skills in their native language to the new language (Gindis, 1997).

Children from immigrant families who have well-developed skills in their first language tend to develop their second language faster and easier (Gindis, 1997). They are also more likely to maintain their native language while they add their second language. This is the additive model of second language acquisition. On the other hand, internationally adopted children often do not have well-developed first language skills, and they follow the subtractive model. In the “subtractive” model of second language acquisition, the first language decreases in use and is replaced by the second language. The process of losing a language occurs more rapidly than the new language is acquired. Normal language attrition is a slow process, but because these children often have little or no contact with their first language, a great deal or all of their primary language skills are quickly lost, often within six months (Pearson, 2001).

### LANGUAGE ASSESSMENT

Given that internationally adopted children present with a large number of risk factors, an evaluation in the child’s native language should be conducted immediately upon his or her arrival to the United States. It can also be beneficial to tape-record the child speaking in his or her native language to a familiar person before he/she is ever exposed to English (Johnson, 1999). Due to the rapid loss of language, assessing language skills after they have been in their new home for six months may not provide an accurate view of their abilities. They may only be having problems acquiring English versus having an actual language disorder. “It is often difficult to differentiate a genuine language disorder from a temporary delay in language

skills in general and second language acquisition in particular” (Judge, 1998). However, if language was assessed immediately upon their arrival it can be extremely useful in determining whether or not they did in fact have an underlying language disorder. Upon evaluation, a great deal of internationally adopted children will show some type of language delay, but they are still able to develop functional English skills in a relatively short amount of time.

Internationally adopted children are often better at thinking and expressing themselves in concrete terms than at understanding and expressing more abstract concepts, which are needed for academic success (Johnson & Dole, 1999). Mastering basic communication skills and conversational fluency does not necessarily ensure future success in school. Two important aspects of language are Communication Language Fluency (CLF) and Communication Language Mastery (CLM). Communication Language Fluency refers to the language skills used in social interactions and every day communication. This normally occurs spontaneously with very little if any formal education, and many internationally adopted children develop CLF with no apparent difficulties. Communication Language Mastery refers to language as a reasoning tool, and a medium for literacy and academic learning. CLM includes metalinguistic awareness, knowledge of the language itself. (Gindis, 1997) CLF develops earlier than CLM, but as they develop the two interact. The early communication experience helps create the foundation for CLM development. “Native speakers are ‘predisposed’ to Cognitive Language Mastery through their earlier experiences with the language” (Gindis, 1997, p94). Children who were deprived of consistent language exposure during their early years of development are more likely to have problems developing CLM. Understanding that two sides to language proficiency exist can help explain why

internationally adopted children may struggle with certain aspects of language acquisition and not others (Gindis, 1997).

Clinicians should be careful about labeling children with specific language problems (Carlucci, 1999). Because internationally adopted children present with a wide variety of risk factors, their symptoms may be the result of any number of problems. Children may have a specific diagnosis that is known to affect speech and language, such as cerebral palsy, fetal alcohol syndrome, or autism. Often times, though, specific etiologies are unknown. Lisa Schoenbrodt, EdD, CCC-SLP at Loyola College in Baltimore stated that “Diagnosis of a specific language or cognitive disorder often is secondary to the attachment problems many of these children experience due to past neglect, abuse, and lack of stimulation” She also stated that sometimes focusing on treating the symptoms is more important than making a specific diagnosis. (Carlucci, 1999).

### INTERVENTION

Post institutionalized children are considered to have special needs, and by federal law states are required to provide early intervention services to children ages 0 to 3 and school based services to older children (PL 99-458) (Carlucci, 1999). The speech pathologist is an important member of the interdisciplinary team serving the needs of infants and toddlers. Certified and licensed speech-language-pathologists are qualified to address a wide range of these children’s needs including delays and disabilities in communication, language, and speech, as well as oral-motor and feeding behaviors (ASHA, 1990).

Early intervention is considered an integral part of treating speech and communication disorders, especially in the internationally adopted population. The “wait and see” attitude is not the best approach for internationally adopted children when it comes to their language.

“The neurological and educational basis of their language development is weaker to begin with. Their chance of recovery on their own seems to be slimmer than in the general population. Therefore, timely help is more crucial for them“ (Gindis, 1997, p95). Although every child’s situation is unique, in general, chances for significant improvement are higher if the right therapy approach is started earlier, rather than later (Gindis, 1997). Johnson and Dole make the following recommendations when working with internationally adopted children:

- Make liberal use of speech and language pathologists and educators specializing in ELL (English Language Learners)
- Model language and avoid correcting as it may inhibit the child from trying to speak.
- Avoid television.
- Encourage imaginary play.
- Seek preschool and play groups with an age mix so that the child can be successful in communicating with younger children while learning from those who are older.
- Recognize that many behaviors associated with attachment disorders and ADHD are also seen in children who are just learning English or who have speech and language delays. As language skills increase, behavior may improve.

Research on post institutionalized children from Eastern Europe found that most children who spent 8 months or more in an institution received some type of special intervention or educational service. The most frequent services were infant developmental programs (39%), speech therapy (22%), special needs day care (11%), and occupational therapy (11%).

THE FUTURE OF INTERNATIONALLY ADOPTED CHILDREN IN THE UNITED STATES

Despite all of the medical, developmental, and social risk factors associated with internationally adopted children, preliminary studies indicated that these children can successfully adjust to their new lives, and that most make tremendous gains in growth during the first two years with their adoptive parents. Gross motor and fine motor coordination, as well as strength, improved with a stimulating environment and proper nutrition. (Hough, 1996). “The vast majority of intercountry adoptees grow up to be happy, well-adjusted adults” (Rojewski & Rojewski, 2001). These children grow up in supportive families who love them and want them to be successful.

## THE INTERVIEWS

### SECTION III

#### INTERVIEW RATIONALE

International adoption is subject that is extremely personal and emotional to all of those involved, and I felt that by speaking with actual parents I would gain further insight into the process. In two of the families I was able to meet and interact with the children, which added an even more personalized aspect to my entire project.

#### THE INTERVIEW PROCESS.

I interviewed four mothers of internationally adopted children in the Muncie, Indiana area. The first half of each interview session focused on the family's individual international adoption experience, from the time that they decided to adopt, to the present. We discussed the various ways in which they prepared for the adoption and the areas in which they would have benefited from more preparation. The second half of the interview focused on the adopted children and included topics such as their adjustment to their new home, their physical growth and development, feeding and oral motor issues, attachment concerns, and their language development. All of the parents were more than willing to discuss their children and share their thoughts and personal adoption experiences with me. In my discussion of the content and results of each interview I do not use the family's actual names. They are referred to as Family A, Family B, Family C, and Family D.

## THE FAMILIES

Each family had a unique and equally memorable adoption story to tell. Family A's adoption story is included in more detail from start to finish and provides an overview of what the adoption process in China entailed. The other two families who adopted from China went through similar experiences, and more condensed versions of their stories are included as well. The fourth family adopted from Guatemala, and the differences in their adoption process are also mentioned. The parents that I interviewed all had varying levels of education and different careers. The parents in three out of four of the families had at least a bachelor's degree. Family A's mother was a speech language pathologist working in a university setting. Family B's mother held a degree in nursing. Family C consisted of a single mother who has held various positions for many years in the health care field. Family D's mother held a bachelor's degree and is currently employed as a Creative Memories consultant. All of the families lived in the Muncie, IN area.

## FAMILY A

Family A brought their first child home from China in August of 2000. The adoption process, which led them up to that moment, began over a year earlier. Once Family A decided that they wanted to adopt, they spent time researching the country they wanted to adopt from, and the adoption agency that they wanted to use. Mrs. A. said that the Internet was a valuable source of information in both finding an adoption agency and in researching issues involved in international adoption in general. Their decision to adopt from China was in a large part due to the availability and the health of the children from that country, as well as the relatively consistent and regulated adoption process. The mother had also traveled to



China on several occasions, and she felt that her fondness for the country would be another connection with her daughter.

Family A contacted their agency in the early spring of 1999, and by September of 1999, had collected all of the paper work for the dossier. China requires each parent to write an autobiography, which they did, and they completed a home study, which ensured that their home was a suitable environment for a child. Eight months later they received a referral, which came from the adoption agency and included the child that they were matched with by the Chinese government. At that time they were told that their daughter was six months old, and had been in the orphanage since she was two days old. They were given her Chinese name, her weight, and the results of a preliminary medical examination. Very little information was included about their daughter's development. They then signed an agreement with China saying they accepted the referral, which was sent back to China. The Chinese government issued a travel approval, and the adoption agency made the arrangements for the family to travel to China.

In late July of 2000, family A arrived in Beijing. They spent two days sightseeing and getting acclimated to the country's food, culture, and time zone. Next, they flew from Beijing to Guangzhou, their baby's home province. They arrived in the city, checked into their hotel, and 30 minutes later, they were holding their daughter in their arms. A group from the orphanage, which included the orphanage director, two nannies and the husband of one of the nannies, brought her, along with three other children. At the same time, two other orphanages were there with children for several other parents in their travel group. They all met in the hotel lobby to receive their children, which meant a rather chaotic moment with numerous crying babies and an equal number of crying parents. Mrs. A described the moment as very

touching and surreal, but rather anticlimactic and lacking of the ceremonial feeling that she expected.

After receiving their daughter, Family A traveled to an office in Guangzhou to begin the necessary paperwork for the Chinese adoption. Adoptions in China are processed through the Chinese legal system, and then the US government recognizes the adoption. Once the paperwork was completed, they were provided with a document indicating that they had legally adopted her, an abandonment certificate, and a birth certificate. At that time they also paid several fees, including the standard three thousand dollar cash donation to the orphanage. By six o'clock that night they had legally adopted their daughter.

Family A spent the rest of the week gathering the documents they would need for their appointment at the US Consulate. Their first task was to obtain their daughter's Chinese passport, which involved a six-hour bus ride and several hours of waiting and nervously answering questions in a passport office. Their daughter was also given a brief medical examination that primarily ensured she would not transmit any contagious diseases back to the US. The end of the week culminated in their appointment at the US Consulate. The Consulate combined the paperwork that was previously submitted through the INS with the recently completed paperwork from China. After answering a few questions, they were told that their daughter would be given a Visa to immigrate to the US. Obtaining the Visa was the family's last major endeavor. Finally, they were able to take their daughter home with them.

Back in the US, at the airport immigration office they began the necessary paperwork for their daughter's green card. This step is now unnecessary because in February of 2001, the law was modified so that any adopted child automatically becomes a US citizen once they reached US soil. Later that year, Family A began the paperwork for the Indiana adoption.

Through that process their daughter was given an Indiana birth certificate, which stated that she was their daughter but was born in China. This also allowed them to legally change her name, and she was also assigned a social security number. Overall, from the time that Family A decided to adopt until the time when all of the adoption paperwork was completed almost two years had passed.

Soon after arriving home, Family A took their daughter to the pediatrician for a complete medical evaluation. They ended up going in earlier than scheduled because their daughter was sick, which is common when internationally adopted children arrive home. The American Academy of Pediatrics has compiled a complete list of tests each child should receive, such as HIV, urine analysis, Tuberculosis, and an entire battery of Hepatitis tests. Their daughter did test positive on a TB skin test, which was most likely due to a TB vaccination she received in China. Since that time she has received three negative chest x-rays for TB. She did not test positive for any other infectious diseases. Overall, the mother felt that her own research combined with the help of her pediatrician led to a very effective and collaborative process when it came to their daughter's medical evaluation

Because of her background in speech-language pathology, Mrs. A was extremely attuned to her daughter's growth and development from the very beginning. She also seemed to be more actively monitoring her daughter's progress than the other parents. Because of this she provided much more detailed answers to the questions on all aspects of her child's development.

When Family A received their daughter, she was 9 months old and weighed 12 pounds, a below average weight for her age. At 10 months of age, she was demonstrating developmental delays in several areas. She was able to roll over, but she could not sit up,

which most children can do around 7 months. By the time they arrived home she was able to sit propped up with pillows and a few weeks later was sitting up on her own. She made rapid progress over the next several months. She crawled at 11 months, stood at 12 months, took her first steps at 13 months, and was walking by 15 months. Her mother described her as “very wobbly” and reported she lost her balance often. Her fine motor skills were also delayed, but she progressed rapidly in that area as well. Mrs. A mentioned several developmentally appropriate toys that were utilized as stimulation. Also, their babysitter was a physical therapist, and she worked with her daughter on developing her motor skills as well. Mrs. A stated that currently, her daughter’s fine motor skills are almost completely caught up, although, she does have some trouble with visual spatial skills.

Mrs. A. also stated that her daughter demonstrated oral motor delays. She gagged a lot as a baby and demonstrated tactile sensitivity. She preferred bland foods and ate baby food until she was 15 months old. She is gradually becoming less sensitive to certain textures and flavors in foods, and has recently started eating meat. It should be noted that these oral motor issues are not uncommon in internationally adopted children due to the feeding practices in orphanages.

Mrs. A provided detailed descriptions of her daughter’s language development. Overall, she said that the first year she was home, her daughter’s language development was slower and did not seem to follow the normal pattern of English development. She reported that her daughter did make some sounds when they first brought her home. She said /mama/ and /baba/, and within a month she was engaging in a great deal more vocal play. Mrs. A stated that her daughter’s babbling reflected more of the Cantonese sounds that she heard for the first 10 months of her life. Her babbling had a lot more intonation and inflection than

American born children, and she produced some phonemes that are not found in English. By her first year she was producing 5 or 6 words, and had a lot of final consonant deletion. The consonants that she acquired first were the common ones between English and Chinese. By the time she was 18 months she had 15 words, which is below average when compared to normal English development. At that time, she was enrolled in the Tiny Tots program at the Ball State University Speech and Language Clinic. Her receptive language skills were always ahead of her expressive language skills, and between 1 and 2 years she was able to follow simple commands. Her parents taught her a few basic signs right away such as “more” and “thank you”. She said that they did teach their daughter some Chinese words, such as hello, thank you, and good-bye. Mrs. A thought that her language development was probably about average, though, for children adopted from Chinese orphanages.

By the time she was 2 years old, her daughter’s language development more closely approximated normal English development. She was saying between 30 and 40 words, but she had no two-word combinations. Around 2 years and 4 months, her vocabulary began to rapidly increase, and Mrs. A thought that she was truly beginning to understand the labels for the objects in her world. She started using plurals and possessives and at 2.5 years had more than 150 words in her expressive vocabulary. Mrs. A. said that she taught her husband how to model words and utterances to promote her language development. Around that time her daughter’s language “suddenly skyrocketed”.

Overall, Mrs. A’s expert knowledge in the areas of child and language development was a great asset when it came to understanding and providing appropriate services for her daughter. Family A took a proactive approach in all areas, especially language development. Their daughter had some difficulties in her English language development, but seems to be

constantly improving. Family A also put a lot of effort into finding the right adoption agency and in preparing to travel to China. Mrs. A stated that she could have benefited from more knowledge on general parenting skills and also on attachment issues. Their daughter did have some attachment difficulties, especially when Mrs. A went back to work full time. She has improved a great deal, however, and seems to be progressing well in all areas.

#### FAMILY B

Family B also adopted a daughter from China. They had two biological children prior to adopting and are currently in the process of adopting another child from China. Their adoption experience with their daughter was extremely positive, and they are looking forward to adding a new member to their family.

Up until they brought back their daughter from China, Family B's adoption process was extremely similar to Family A's. All children are unique, however, so from that point on their experience was unique as well. When they first saw their daughter in China she was 9 months old. At that time she had a bad cough, and they gave her antibiotics from the Texas Medical Kit, which all parents are advised to bring. She cried for entire day, but then slept through that first night. She never had any problems sleeping and has consistently slept through the night since then. No major issues arose while in China. Her medical examination in the United States was clear of any infectious diseases or other medical complications. Her doctor said that she was in the 10<sup>th</sup> percentile for height and weight on the American scale.

From the very beginning, Family B had difficulty feeding their daughter formula. They discovered that if they heated the formula to a high than average temperature she would drink it more readily. They thought that she was used to the high temperature from the orphanage. They gradually decreased the temperature and eventually she would drink it at a

normal temperature. Mrs. B said that when she was in the orphanage she ate eggs and potatoes so she never had any trouble with solid foods. Now, she has a normal healthy appetite for a two year old.

When Family B's daughter first arrived home she was clearly behind in her motor development. Mrs. B said that her head was flatter than normal, which she attributed to lying in a crib for extended periods of time. She engaged in rocking and head banging for two to three weeks after they brought her home. She could not sit up at 9.5 months and was overall very rigid and immobile. They enrolled her in First Steps for occupational therapy to help improve her gross motor skills. She never was able to crawl but began walking at 18 months.

First Steps also recommended that their daughter see a speech pathologist; however Mrs. B felt that this was unnecessary and did not follow through. She remarked that her daughter had only been in the country for a few months, which was not enough time for her to grow used to the new language. She did not seem to be concerned that because her daughter had other developmental delays she might have speech and language delays as well. Currently, she said that her daughter's English skills are rapidly expanding, and her speech seems like that of any other two year old.

Mrs. B said that the most frightening incidents with their daughter occurred as a result of her breath holding episodes. After being at home for two weeks she began holding her breath until she passed out, mostly when she was agitated or upset. The pediatrician explained that part of it was probably genetic, and they discussed ways to prevent and deal with the episodes. Mrs. B said that the incidents have decreased in amount and severity, and she feels that they will gradually disappear.

Overall, Mrs. B seemed to accept the special needs of her adopted daughter as issues that they were fully capable of handling. Her background as a nurse probably helped her deal with her daughter's early difficulties more rationally than other parents might have. She seemed like an extremely relaxed parent, which may have been because she already had two sons. She did not hesitate to enroll her daughter in occupational therapy, however she did not seek any speech or language services, even when recommended.

### FAMILY C

Family C, from Hartford City, Indiana, consisted of a single mother with an adopted child from China. Ms. C. worked in the billing office of a pathologist lab, and has worked in several health care facilities throughout her career. When asked how she prepared for the adoption process Ms. C replied that in many ways she had been preparing for it her entire life. She said that by age 10 she knew that she was going to adopt a child someday. In December of 1998, she began to turn that dream into a reality, even though she did not have the full support of her family. They were concerned about her being a single mother and felt that she would not have the financial resources for the adoption. Ms. C. chose to go through with the adoption anyway. She said that now her family is extremely supportive and convinced that she made the right decision.

Ms. C. began the adoption process much like the other families. She searched the Internet for the best adoption agencies, and ended up choosing the same one as Family B. Her decision to adopt from China was based on her research into the conditions of the orphanages and the health of the children. At that time, China, was also allowing single parents to adopt, while many other countries did not. Ms. C said that she spent at least 2 hours a night on the Internet for information on various topics, and she also read some books written by other



people who had adopted from China. For the most part though, she thought that there was no really good way to prepare because she never knew what was going to happen once she arrived in China.

Ms. C. and her mother went to China in April of 2000 and spent three days in Beijing sightseeing and accustoming themselves to the country. She remarked that her entire trip was like a dream. On April 10th she held her child in her arms for the first time. She was 9.5 months old and weighed 14 pounds. Ms. C. described her daughter as having “the orphanage stare”, meaning that she did not smile, laugh, or look at anything in particular. At that time, her daughter also had bronchitis, double ear infections, and was cutting a tooth. These were not diagnosed until after they arrived home, but while in China Ms. C. knew that her daughter was sick and consulted her physician at home through e-mail. He recommended that she immediately give her daughter the antibiotics from the Texas Medical Kit.

Shortly after arriving home Ms. C. enrolled her daughter in physical therapy 3 times per week at the offices where she worked. The therapist focused on her daughter’s gross motor skills and on getting her to sit up. They also worked on rolling over, which she was able to do within a couple of weeks. Her daughter progressed to crawling and the physical therapy was gradually reduced to 1 day a week over the course of 3 months. During physical therapy her daughter’s personality began to emerge as well. Physical therapy was the only intervention service that her daughter has received. Her mother says her gross motor skills are fine now, and she has not noticed any difficulties with her fine motor skills.

Ms. C’s daughter attached to her right away and has had no major attachment problems. She can be away from her mother for short periods of time while on group outings with other children. She is also very close to her grandparents, especially her grandfather,

although she clearly prefers her mother. She does have difficulty sleeping, which her mother attributes to wanting to be near someone.

Ms. C said her daughter has had no problems with or aversions to certain foods. When they first brought her home, she would eat some rice but mainly drank formula. She easily transitioned to solid foods, and her current eating habits are normal for her age.

According to Ms. C, her daughter “picked up language fast”. By her first birthday she had a few “little words”, but now she “talks all of the time” in full sentences. She loves telling stories beginning with “once upon a time” and ending with “happily ever after”, and is at least 85% intelligible to an unfamiliar listener. Her doctor said she seemed ahead of schedule in her language development, and Ms. C. did not seem concerned that she would have any future difficulties.

#### FAMILY D

Family D has two adopted children from Guatemala, a boy and a girl, who are 20 months apart in age. The adoption process in Guatemala is somewhat different than in China and works through attorneys. Birth mothers who want to place their children up for adoption contact the attorneys. The attorneys then arrange for the children to be placed in foster homes during the adoption process. The adoption agencies in the US contact the lawyers, and the adoptions are processed through them. Mrs. D. said that she chose Guatemala primarily because of this system, which at least kept the children out of orphanages. Family D’s adoption process also took only 13 months from start to finish, which is less time than in many other countries.

Much like the other families, Mrs. D. said that she utilized the Internet to research the international adoption process. In addition, though, she was involved in an infertility support

group that provided information on both domestic and international adoptions. They decided to internationally adopt because it took less time and “seemed like the natural thing to do”. Once the family chose to adopt from Guatemala, she and her husband began researching the country’s culture and people. They read books, searched the Internet and even attended some interracial/ transcultural adoption conferences in Indianapolis.

Family D adopted their son when he was 9 months old. At that point, he could not sit up, and his motor skills were delayed. Within two weeks of being home, though, he was sitting up. Around 14 months he was walking. From the beginning, Mrs. D. said that he was an easy baby. When she received him at the Embassy in Guatemala, he was smiling and animated. Once they were home, he adjusted immediately and had no attachment problems. He never had any eating difficulties, and now will eat almost anything.

Their greatest concern with him was his language development. Mrs. D. described him as a “late bloomer”. By 2 years he was only saying 6 words. They enrolled him in first steps, through which he received speech therapy and play based therapy for approximately 8 months. The speech pathologist evaluated his language as 9 months behind what is normal for his age. This made sense to Mrs. D because her son was 9 months old when he was adopted. Mrs. D. said that after a few months of therapy, though, his language exploded. Currently, her son is in preschool, and he is attending a preschool language class through Muncie City Schools. He has some articulation sounds in error, but is at least 70% intelligible even to an unfamiliar listener. His articulation and language are improving, and overall he is doing extremely well. Next year he will attend pre-kindergarten instead of regular kindergarten because Mrs. D. wants to make sure he progresses at his own pace.

Family D also adopted a daughter from Guatemala. She is 20 months younger than their son. Their daughter had a more difficult time adjusting. She had a very strong attachment to her foster mother, and Mrs. D. said that she cried for the first 5 hours that they had her. After approximately one month, though, she seemed to be adjusting well to her new home.

Developmentally in all areas, her daughter made rapid progress. She was sitting at 8 months and walked at 11 months. She has never had any speech and language issues. By 14 months her vocabulary was above average for her age, and she currently has no articulation problems. Her mother stated that she is extremely smart and feels that she will have no difficulties in school.

In general both of Family D's adoption experiences were positive. Mrs. D said that they wished they had put more time into researching an agency, even though everything turned out fine. She felt that they were extremely lucky throughout the entire process. In reference to her children Mrs. D stated, "It's like they were always here. It's like they were always with us."

## CONCLUSION

I feel that the people I interviewed were a fair representation of parents of internationally adopted children, at least in the Muncie, IN area. The children seemed well adjusted and were being raised in supportive and caring families. Their families had spent time researching international adoptions and were prepared for the impact a child would have on their lives. They were aware that by internationally adopting, their children would be at a higher risk for certain developmental and language concerns. All of the families enrolled their children in some type of physical or occupational therapy because they displayed

obvious gross and fine motor delays. Only two of the children received any type of speech or language services. Families A and D seemed to have increased concern for their children's speech and language development. The other families were aware that their children may have had difficulties, but were less concerned about language than with the motor and developmental issues. Further parental education on possible risk factors related to the speech and language development of internationally adopted children would be beneficial. Overall, though, I felt that all of the parents were committed to making sure that their children received proper intervention services.

#### THE FUTURE OF INTERNATIONALLY ADOPTED CHILDREN IN THE UNITED STATES

The number of internationally adopted children in the United States continues to rise, further increasing the demand for professionals who are qualified to provide them with appropriate services. Health care professionals such as Pediatricians, Physical and Occupational Therapists, and Speech Pathologists, who are most likely to work with these individuals early on, should be familiar with the risk factors associated with this population. Internationally adopted children do not necessarily follow the developmental norms for typically developing American children. Also, the issues and concerns among them are likely to differ depending on their country of origin and the level of care that they received in that country. In addition to early intervention services, appropriate special education and ESL programs should account for any special needs that school-aged internationally adopted children might have. Classroom teachers, special education teachers, and other school personnel need to understand that internationally adopted children may not easily be categorized based on normal diagnoses.

In order for appropriate intervention services to be provided, further research needs to be conducted across several areas related to the internationally adopted population. Health care professionals and parents would benefit greatly if developmental norms were established for both their physical and language development. In the field of speech pathology alone, countless research possibilities exist, including the following: normal delays in language development associated with subtractive bilingualism, English as a Second Language (ESL) in older children, the prevalence and causes of language disorders, and oral motor problems in the internationally adopted population. Also, more country specific research needs to be done. Much of the existing literature discusses the research based on children from Eastern Europe and Russia, where the standards of care were thought to be the poorest. Currently, very little research exists on the health and development of children from China, even though it is the primary country for international adoptions. Norms that were developed based on Russian children might not apply to children from China and Latin America.

The thousands of internationally adopted children growing up in loving families throughout the United States have been given a second chance at a new life. They will have access to opportunities they might otherwise have never imagined. Many of the challenges that internationally adopted children face can be overcome, but they must first be recognized and understood. Therefore, it is the responsibility of parents, health care professionals, and educators to provide them with appropriate services early on so that their future possibilities are not limited by their past.

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**INSTITUTIONAL REVIEW BOARD**

TO: April Nelson  
900 N. New York #404  
Muncie, IN 47303

FROM: Sharon Paulson,  Chair  
Institutional Review Board

DATE: March 29, 2002

RE: Human Subjects Protocol I.D. – IRB #02-191

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The Institutional Review Board has recently approved your project titled “Challenges and Issues of Internationally Adopted Children with a Specific Focus on their Acquisition of English as a Second Language” as submitted as an expedited study. Such approval is in force from March 28, 2002 to May 31, 2002.

It is the responsibility of the P.I. and/or faculty supervisor to inform the IRB:

- when the project is completed, or
- if the project is to be extended beyond the approved end date,
- if the project is modified,
- if the project encounters problems,
- if the project is discontinued.

Any of the above notifications should be addressed in writing to the Institutional Review Board, c/o the Office of Academic Research & Sponsored Programs (2100 Riverside Avenue). Please reference the above identification number in any communication to the IRB regarding this project. Be sure to allow sufficient time for extended approvals.

pc: Karen Thatcher, Speech Pathology and Audiology



## Human Participant Protections Education for Research T

### Completion Certificate

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This is to certify that

**April Nelson**

has completed the **Human Participants Protection Education for Research Teams** online course, sponsored by the National Institutes of Health (NIH), on 03/07/2002.

This course included the following:

- key historical events and current issues that impact guidelines and legislation on human participant protection in research.
  - ethical principles and guidelines that should assist in resolving the ethical issues inherent in the conduct of research with human participants.
  - the use of key ethical principles and federal regulations to protect human participants at various stages in the research process.
  - a description of guidelines for the protection of special populations in research.
  - a definition of informed consent and components necessary for a valid consent.
  - a description of the role of the IRB in the research process.
  - the roles, responsibilities, and interactions of federal agencies, institutions, and researchers in conducting research with human participants.
- 

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**COMPLETE AND PRINT ALL PAGES. ATTACH THIS PRINTED PAGE TO THE PROTOCOL.  
REVIEW THE ACCOMPANYING PROTOCOL GUIDELINES.**

**Exempt Review Check List**

Indicate the most appropriate category(s) that apply to the proposed project.

- ☐ 1. Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as (i) research on regular and special educational instructional strategies, or (ii) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.
- ☐ 2. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaged to the subjects' financial standing, employability or reputation.
- ☒ 3. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior that is not exempt under the previous category, if: (i) the human subjects are elected or appointed public officials or candidates for public office; or (ii) federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.
- ☐ 4. Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects. [NOTE: the data, documents, records, or specimens must be in existence before the project begins.]
- ☐ 5. Research and demonstration projects which are conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine: (i) public benefit or service programs; (ii) procedures for obtaining benefits or services under those programs; (iii) possible changes in or alternatives to those programs or procedures; or (iv) possible changes in methods or levels of payment for benefits or services under those programs.
- ☐ 6. Taste and food quality evaluation and consumer acceptance studies, (i) if wholesome food without additives are consumed or (ii) if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.

**It should be noted that the Exempt Review categories do not apply to:**

- A) Research involving prisoners, fetuses, pregnant women, or human in vitro fertilization.
- B) Research involving survey or interview procedures or observation of public behavior of minors, except for research involving observations of public behavior when the investigator(s) do not participate in activities being observed.
- C) Research involving the deception of the subject.

While the investigator may request that a research protocol receive an Exempt Review, the IRB may determine that such a review is not appropriate if there exists any potential risk to the subject. In such a case, the protocol will receive the type of review (Expedited or Full Review) deemed appropriate by the IRB.

**Ball State University  
Institutional Review Board (IRB)  
Human Subject Research Application**

Exempt Review

(IRB use only ) IRB#

Title: Challenges and Issues of Internationally Adopted Children with a Specific Focus on thier Acquisition of English as a Second Language

Principal Investigator (PI): April Nelson

Rank: Undergraduate

Department: Speech Pathology

Email: aprilnel@aol.com

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correspondence will be sent

900 N. New York #404  
Muncie, IN 47303

Telephone: 765-747-5028

Anticipated Project Dates: Begin 3/20/02 End 5/1/02

If this project is funded or if the investigator is seeking funding, list the agency(s) and/or sources(s):

To comply with the federally mandated educational requirement, have you, as the PI and all of the key personnel for the proposed research project, completed the on-line tutorial (<http://cme.nci.nih.gov>) on the protection of human subjects?

☒ yes

☐ no

As a result of the federal regulations, protocols submitted to the IRB without this requirement successfully completed will not be reviewed until the requirement has been met.

A printout of the computer generated certification of your successful tutorial completion must be either attached to this protocol application or be on record in the Office of Academic Research and Sponsored Programs.

**IRB ASSURANCE STATEMENT**

I have read and understand Ball State University's Policy for the Protection of Human Subjects in Research as stated in the *Faculty and Professional Personnel Handbook* and I agree:

- a) to accept responsibility for the scientific and ethical conduct of this research study;
- b) to obtain IRB approval prior to revising or altering the research protocol or the approved Informed Consent form;
- c) to immediately report to the IRB any serious adverse reactions and/or unanticipated effects on subjects which occur as a result of this study.

April Nelson  
PI Signature  
April Nelson

3/17/02  
Date

**FACULTY ADVISOR/SPONSOR ASSURANCE STATEMENT**

As the Faculty Advisor/Sponsor, I certify that I have reviewed this protocol and affirm that merit of this research project and the competency of the investigator(s) to conduct the project. (A signature is required for all student research projects, and for all persons not affiliated with Ball State University.)

Karen Thatcher  
Signature  
KAREN Thatcher  
Type Name

3-20-02  
Date

For IRB use

Approval Date:

Continuing Review:

## PROTOCOL INFORMATION

List all persons, other than the PI, who will have a role in the research project (if necessary include an additional sheet of paper):

Name: Karen Thatcher Rank: Fac Department: Speech Pathology and Audiology  
Responsibilities: \_\_\_\_\_

Name: \_\_\_\_\_ Rank: Fac Department: \_\_\_\_\_  
Responsibilities: \_\_\_\_\_

Name: \_\_\_\_\_ Rank: Fac Department: \_\_\_\_\_  
Responsibilities: \_\_\_\_\_

Name: \_\_\_\_\_ Rank: Fac Department: \_\_\_\_\_  
Responsibilities: \_\_\_\_\_

Description of subject population:

Number of subjects: 4

Gender of subjects:  
(check one)

- ☐ Males only  
☒ Females only  
☐ Both males and females

Age range(s): adults

Check all categories that apply to the subjects:

- ☐ Cognitively impaired  
☐ Minors (individuals under the age of 18 yrs.)  
☒ Normal/Healthy volunteers  
☐ Patients/Clients  
☐ Other, explain: \_\_\_\_\_

- ☐ Pregnant women  
☐ Prisoners  
☐ Students  
☐ Student Athletes

Will any information pertaining to the research be withheld from the subjects (i.e., as in a deception study)?

☐ yes ☒ no

If yes, for what purpose? \_\_\_\_\_

List the location(s) where the research will be conducted: On Ball State University campus or at another convenient location

If an advertisement(s) will be used to recruit subjects, indicate the format(s) to be used:

- ☐ Flyer ☐ Radio  
☐ Newspaper ☐ Television (e.g., public access channel)  
☐ Electronic media, describe: \_\_\_\_\_  
☒ Other, describe: The subjects were asked individually to participate

\*\*\* ATTACH COPIES OF ALL ADVERTISEMENTS TO THE PROTOCOL \*\*\*

If any part of the research is to be conducted at another institution with a collaborator, provide the following information for that person:

Name: \_\_\_\_\_

Address:

Telephone number: \_\_\_\_\_ Email address: \_\_\_\_\_

If any part of the research is to be conducted at an institution, or in conjunction with another organization, other than Ball State University, provide the name and contact information for a person who can give permission to conduct the research. (This generally will be the person who will write the letter of permission to conduct the research.)

Name: \_\_\_\_\_

Address:

Telephone number: \_\_\_\_\_ Email address: \_\_\_\_\_

**AFTER PRINTING THE HUMAN SUBJECT RESEARCH APPLICATION FORM,  
SELECT THE CORRECT PROTOCOL REVIEW BUTTON.**

## **SECTION 1**

### **1. Title**

Challenges and Issues of Internationally Adopted Children with a Specific Focus on their Acquisition of English as a Second Language

### **2. Purpose of the study**

This study is part of my Senior Honors project. I am choosing to do my Honors project on internationally adopted children and their language development. My project incorporates several of my areas of interest within and outside of the field of speech pathology. It will allow me to explore the subject of international adoption as well as second language acquisition and bilingualism. I hope that this project will provide an increased awareness of and sensitivity on the situations of internationally adopted children in the United States. Health care professionals, including speech pathologists, involved in the intervention process need to be aware of the children's' backgrounds and familiar with their associated risk factors and potential problems. My project will focus specifically on the issues related to speech pathology, but the information that I present should be of interest to any person working with an internationally adopted child. I also expect to provide a rationale for the importance of future research, including specific areas related to the field of speech pathology.

### **3. Rationale**

The language development of children is an extremely important area of research in the field of speech pathology, but very little research exists on the language development of internationally adopted children. My coursework so far at Ball State has provided me with a basic understanding of speech and language development, as well as the assessment and intervention practices involved in treating people with language disorders. The goal of my project is to expand on this knowledge by researching a specific population. Internationally adopted children are a population that is expanding rapidly in the United States, and the need for professionals with the knowledge and skills to work with these children is also drastically increasing.

The final result of this project will be a paper, which will provide an overview of the current literature on internationally adopted children that relates to speech pathology. I will provide some background information on international adoptions in the United States and the reasons for the dramatic increase in these adoptions over the past ten years. I will discuss the living conditions and the environments that many internationally adopted children live in before they are adopted. This background will lead into the high risk factors and problems that are found in the internationally adopted population. I will discuss the medical and developmental concerns, and then I will go into further detail about the language concerns. I will focus on the process of normal language acquisition and the possible reasons for delays in this population. I will also provide an overview of second language acquisition and the possible problems these children may have in learning English. I will then outline the role of the speech pathologist in the assessment and intervention process.



The second part of my paper will discuss the results of my interviews with several parents of internationally adopted children. My interview with these parents will focus on the amount of preparation they received before and during the adoption process and the services they received after their children were adopted. Because of the rapid increase in international adoptions and the lack of significant research in the area, one major concern is that parents are not fully prepared to take on the responsibility of these children. They may not expect to adopt a child that may have developmental, behavioral, and/or language concerns, and when the problems surface they do not know who to turn for help. I also am interested in how the parents view their child's language development, and how they have helped facilitate their child's language development in English and/or their native language. By talking with parents who have already adopted children I hope to obtain an overall better understanding of the adoption process and the areas in which parents wish they had been better prepared.

## **SECTION II- DESCRIPTION OF SUBJECT POPULATION**

- 1. Number of subjects-Four**
- 2. Describe the subject population**

The interview subjects will be the parents of internationally adopted children.

## **SECTION III- SUBJECT RECRUITMENT**

- 1. Describe the method of subject recruitment.**

My subjects will be asked to participate in the project by Theresa McClain, one of my advisors, who is also a parent of an internationally adopted child. All of the subjects will be people she knows or has had contact with through her own adoption experience.

## **SECTION IV- METHODS AND PROCEDURES**

- 1. Describe the methods and procedures to be used.**

The interviews will take place on Ball State University's campus in a private room in the Department of Speech Pathology and Audiology or over the phone.

## **SECTION V- ANONYMITY/CONFIDENTIALITY OF DATA**

- 1. Describe how data will be collected and stored.**

The subjects' responses to the interview questions will be recorded on audiocassettes and the cassette tapes will be labeled with the subjects' names and the dates of the interviews. Hand written notes will also be taken at the time of the interviews. The questions and responses will be incorporated into the final paper, but the subjects' names will not be included.

## **SECTION VI- SUBJECT INCENTIVES/INDUCEMENTS TO PARTICIPATE**

Not applicable